		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040816

Facility Name: Emerald Park Health Care Center

Address: 9125 South Pulaski Rd. (Number) Evergreen Park (City) 60642 (Zip Code)

County: Cook

Telephone Number: (708) 425-3400 **Fax #** (708) 425-5086

IDPA ID Number: 363473443001

Date of Initial License for Current Owners: 02/11/1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Sanford B. Alper - Principal
Kessler, Orlean, Silver, & Co. P.C.
(Firm Name & Address) 1101 Lake Cook Road. Suite C
Deerfield, Illinois 60015-5233
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 249

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	163	Skilled (SNF)	163	59,495	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,390	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	90,885	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	82,835	3,094	1,347	87,276	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	82,835	3,094	1,347	87,276	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.03%

D. How many bed-hold days during this year were paid by Public Aid?
915 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/11/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 1,249

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	224,674	23,520	9,780	257,974		257,974	0	257,974			1
2	Food Purchase		355,312		355,312		355,312	0	355,312			2
3	Housekeeping	303,858	41,585	34,253	379,696		379,696	0	379,696			3
4	Laundry	80,370	15,865	2,731	98,966	0	98,966	0	98,966			4
5	Heat and Other Utilities			104,367	104,367		104,367	0	104,367			5
6	Maintenance	106,379		81,187	187,566		187,566	0	187,566			6
7	Other (specify):*			52,875	52,875		52,875	0	52,875			7
8	TOTAL General Services	715,281	436,282	285,193	1,436,756	0	1,436,756	0	1,436,756			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000	0	7,000			9
10	Nursing and Medical Records	2,312,427	61,352	7,981	2,381,760		2,381,760	0	2,381,760			10
10a	Therapy	91,075		22,412	113,487		113,487	0	113,487			10a
11	Activities	74,916	23,668		98,584		98,584	0	98,584			11
12	Social Services	109,456			109,456		109,456	0	109,456			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,587,874	85,020	37,393	2,710,287	0	2,710,287	0	2,710,287			16
	C. General Administration											
17	Administrative	169,927		23,357	193,284		193,284	0	193,284			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			70,581	70,581		70,581	145	70,726			19
20	Dues, Fees, Subscriptions & Promotions			17,375	17,375		17,375	(1,444)	15,931			20
21	Clerical & General Office Expenses	180,260	25,941	92,435	298,636		298,636	(3,774)	294,862			21
22	Employee Benefits & Payroll Taxes			596,449	596,449		596,449	17,276	613,725			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			2,138	2,138		2,138	0	2,138			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			270,953	270,953		270,953	0	270,953			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	350,187	25,941	1,073,288	1,449,416	0	1,449,416	12,203	1,461,619			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,653,342	547,243	1,395,874	5,596,459	0	5,596,459	12,203	5,608,662			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Emerald Park Health Care Center #0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			173,022	173,022		173,022	168,833	341,855			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			3,012	3,012		3,012	533,602	536,614			32
33	Real Estate Taxes				0		0	292,673	292,673			33
34	Rent-Facility & Grounds			1,010,571	1,010,571		1,010,571	(1,010,571)	0			34
35	Rent-Equipment & Vehicles			14,590	14,590		14,590	0	14,590			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,201,195	1,201,195	0	1,201,195	(15,463)	1,185,732			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			62,898	62,898		62,898	0	62,898			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			136,328	136,328		136,328	0	136,328			42
43	Other (specify):* **Franchise Tax**			78	78		78	(78)	0			43
44	**TOTAL Special Cost Centers**	0	0	199,304	199,304	0	199,304	(78)	199,226			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,653,342	547,243	2,796,373	6,996,958	0	6,996,958	(3,338)	6,993,620			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(28,675)	30		9
10	Interest and Other Investment Income	(2,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(9,675)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,533)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,133)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	38,796		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 38,796		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,337)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Emerald Park Health Care Center

ID# 0040816

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-deductible Dues	$ (1,444)	20	1
2	Franchise Tax	(89)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,533)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	145	0	0	0	0	0	0	0	0	0	145	19
20	Fees, Subscriptions & Promotions	(1,444)	0	0	0	0	0	0	0	0	0	0	(1,444)	20
21	Clerical & General Office Expenses	(9,699)	5,925	0	0	0	0	0	0	0	0	0	(3,774)	21
22	Employee Benefits & Payroll Taxes	0	17,276	0	0	0	0	0	0	0	0	0	17,276	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,143)	23,346	0	0	0	0	0	0	0	0	0	12,203	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,143)	23,346	0	0	0	0	0	0	0	0	0	12,203	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(28,675)	0	197,508	0	0	0	0	0	0	0	0	168,833	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,226)	0	535,828	0	0	0	0	0	0	0	0	533,602	32
33	Real Estate Taxes	0	0	292,673	0	0	0	0	0	0	0	0	292,673	33
34	Rent-Facility & Grounds	0	0	(1,010,571)	0	0	0	0	0	0	0	0	(1,010,571)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,901)	0	15,438	0	0	0	0	0	0	0	0	(15,463)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(89)	11	0	0	0	0	0	0	0	0	0	(78)	43
44	**TOTAL Special Cost Centers**	(89)	11	0	0	0	0	0	0	0	0	0	(78)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,133)	23,357	15,438	0	0	0	0	0	0	0	0	(3,338)	45

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	24.50%	Balmoral Nursing Home	Chicago	Nivram Mgmt., Inc.	Chicago	Nurs. Home Mgmt.
Doreen Mermelstein	24.50%	Winston Manor Nursing Home	Chicago	EMI Enterprise, Inc.	Lincolnwood	Nurs. Home Mgmt.
Morris Esformes	51.00%	Central Nursing Home	Chicago	M. Mermelstein Pts	Chicago	Lessor
		Sovereign Healthcare, L.L.C.	Chicago			
		Chicago Ridge Nursing Home	Chicago			
		See Attachment				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting	$	Nivram Management, Inc.	24.50%	$ 145	$ 145	1
2	V	21	Bank Charges		Nivram Management, Inc.	24.50%	171	171	2
3	V	21	Insurance		Nivram Management, Inc.	24.50%	1,431	1,431	3
4	V	21	Office Expenses		Nivram Management, Inc.	24.50%	171	171	4
5	V	21	Repairs & Maint.		Nivram Management, Inc.	24.50%	90	90	5
6	V	21	Supplies		Nivram Management, Inc.	24.50%	3,370	3,370	6
7	V	43	Franchise Tax		Nivram Management, inc.	24.50%	11	11	7
8	V	22	Payroll Taxes		Nivram Management, Inc.	24.50%	17,276	17,276	8
9	V	21	Telephone		Nivram Management, Inc.	24.50%	668	668	9
10	V	21	State Replacement Tax		Nivram Management, Inc.	24.50%	24	24	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 23,357	$ * 23,357	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	M. Mermelstein Partnership	100.00%	$ 197,508	$ 197,508	15
16	V								16
17	V	32	Interest Expense		M. Mermelstein Partnership	100.00%	535,828	535,828	17
18	V	33	Real Estate Taxes		M. Mermelstein Partnership	100.00%	292,673	292,673	18
19	V	34	Rent	1,010,571	M. Mermelstein Partnership	100.00%		(1,010,571)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,010,571			$ 1,026,009	$ * 15,438	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Marvin Mermelstein	Asst. Administrator	Administrative	24.50%	85,074	4	21.23%	Salary	$ 22,926	L17, Col 1	1
2	Marvin Mermelstein	Plant Supervisor	Support	See Above	127,611	6	21.23%	Salary	34,389	L6, Col 1	2
3	Doreen Mermelstein	Office Manager		24.50%	88,876	5	14.18%	Salary	14,684	L 21, Col 1	3
4	Henry Mermelstein	Administrative	Administrative	0.00%	223,168	9	10.73%	Salary	26,832	L 17, Col 1	4
5	Louise Mermelstein	Food Svce Supervsr		0.00%	90,000	0	0.00%		0		5
6	Joseph Mermelstein		Administrative	0.00%	95,000	0	0.00%		0		6
7	Morris Esformes	Administrative	Administrative	51.0%	155,294	2	3.00%	Salary	4,706	L 17 Col 1	7
8					See Attached Schedule B						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,537		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	1,173	6	$ 805	$	249	$ 171	1
2	21	Office Expenses	Resident Beds	1,173	6	805		249	171	2
3	21	Supplies	Resident Beds	1,173	6	15,880		249	3,370	3
4	43	Franchise Tax	Resident Beds	1,173	6	50		249	11	4
5	19	Accounting	Resident Beds	1,173	6	682		249	145	5
6	22	Payroll Taxes	Resident Beds	1,173	6	81,386		249	17,276	6
7	21	Telephone	Resident Beds	1,173	6	3,145		249	668	7
8	21	Repairs & Maint.	Resident Beds	1,173	6	424		249	90	8
9	21	Insurance	Resident Beds	1,173	6	6,740		249	1,431	9
10	21	State Replacement Tax	Resident Beds	1,173	6	115		249	24	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 110,032	$		$ 23,357	25

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mid-North		X	Mortgage	$35,230.00	01/01/96	$ 2,995,849	$ 0	04/01/2010	0.1125	$ 21,446	1
2	Crawford		X	Mortgage	$8,826.00	01/01/96	755,801	0	01/01/2012	0.1200	5,560	2
3	Diplomat		X	Mortgage	$26,440.00	01/01/96	2,474,350	0	01/01/2019	0.1200	52,742	3
4	Cole-Taylor		X	Mortgage	$52,178.45	01/21/02	7,300,000	7,223,785	02/05/2007	0.0713	456,079	4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	Interest	01/08/02	263,000	180,000	Open	Prime	3,013	6
7												7
8												8
9	TOTAL Facility Related				$122,674.45		$ 13,789,000	$ 7,403,785			$ 538,840	9
	B. Non-Facility Related*											
10	Interest Income Offset										(2,226)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (2,226)	14
15	TOTALS (line 9+line14)						$ 13,789,000	$ 7,403,785			$ 536,614	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 282,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 283,073	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,073	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 291,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 292,673	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	261,531	8
	1998	259,589	9
	1999	266,222	10
	2000	273,716	11
	2001	283,073	12

2001 Tax Bill = $283,073.
Est. Increase = 1.03
Est. Tax = $291,565.
Use $291,600.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040816

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-02-300-046-0000	Emerald Park Nursing Home	$ 29,273.92	$ 29,273.92
2.	24-02-300-047-0000	Emerald Park Nursing Home	$ 169,199.46	$ 169,199.46
3.	24-02-300-048-0000	Emerald Park Nursing Home	$ 84,599.54	$ 84,599.54
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 283,072.92	$ 283,072.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,246 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1996	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	249		1996	1976	$ 6,402,500	$		$ 213,417	$ 213,417	$ 1,337,953	4
5					(359,068)						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1987	65,253	0	20	3,263	3,263	51,218	9
10	Building Improvements			1987	16,408	0	19	864	864	5,183	10
11	Building Improvements			1987	1,924	0	15	60	60	1,924	11
12	Building Improvements			1987	7,771	0	5			7,771	12
13	Building Improvements			1988	9,570	0	20	479	479	6,561	13
14	Building Improvements			1988	6,960	0	19	366	366	5,348	14
15	Building Improvements			1989	7,955	0	20	398	398	2,713	15
16	Building Improvements			1989	5,500	0	15	367	367	4,944	16
17	Building Improvements			1990	34,570	0	20	1,729	1,729	21,932	17
18	Electrical			1991	1,658	0	31.5	53	53	620	18
19	Elevator			1991	75,000	0	31.5	2,381	2,381	24,190	19
20	Remodeling			1991	3,668	0	31.5	116	116	1,281	20
21	Alarm Detection			1992	2,700	0	31.5	86	86	325	21
22	Curtains & Tracks			1992	16,416	0	31.5	521	521	5,405	22
23	Building Improvements			1993	63,956	0	39	1,640	1,640	16,657	23
24	Building Improvements			1994	3,221	0	39	83	83	705	24
25	Building Improvements			1994	3,500	0	39	90	90	765	25
26	Hot Water Heater			1994	1,985	0	39	51	51	433	26
27	Building Improvements			1995	9,054	357	39	232	(125)	1,740	27
28	Replace Floors in Entire Facility			1996	63,110	1,618	30	2,104	486	13,676	28
29	Wallpapering			1996	3,646	93	30	122	29	793	29
30	Drapery & Curtains			1996	12,244	314	30	408	94	2,652	30
31	Pavement - Driveway			1996	6,600	169	30	220	51	1,430	31
32	Remodeling Shower Rooms, Bathroom & Rehab Rooms			1996	171,960	4,410	30	4,410		35,936	32
33	New Lobbies & Nursing Station			1997	69,250	1,776	39	1,776		9,435	33
34	Kitchen Electrical			1997	3,578	92	7	511	419	2,601	34
35	Fire Door			1997	520	13	7	74	61	377	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioner	1997	$ 2,205	$ 57	39	$ 57	$	$ 313	37
38	Time Clock System	1998	4,958	127	39	127		572	38
39	Plumbing	1998	5,398	138	39	138		621	39
40	Air Conditioning	1998	4,239	109	39	109		490	40
41	Roof	1998	1,562	40	39	40		180	41
42	Tuckpointing	1999	1,917	49	39	49		172	42
43	Fire Alarm	1999	1,420	36	39	36		126	43
44	Fence	1999	3,367	86	39	86		301	44
45	Windows	1999	4,677	120	39	120		420	45
46	HVAC Work	1999	2,946	76	7	76		266	46
47	Painting	1999	42,104	5,260	7	6,015	755	21,052	47
48	Wallpaper	1999	4,804	840	7	686	(154)	2,401	48
49	Cubicle Curtains	1999	17,937	2,241	7	2,562	321	8,967	49
50	Drapes	1999	2,436	304	7	348	44	1,218	50
51	Carpeting	1999	2,788	348	7	398	50	1,393	51
52	Fire Dampers	2001	1,190	31	39	31	0	31	52
53	Roofing	2001	2,838	73	39	73	0	73	53
54	Flooring	2001	5,320	137	39	136	(1)	136	54
55	Exterior Brick	2001	300	8	39	8	0	8	55
56	Discharge Vents	2001	6,948	176	39	178	2	178	56
57	Windows	2001	1,680	43	39	43	(0)	43	57
58	Windows	2001	1,550	40	39	40	0	40	58
59	Elevator	2001	5,972	153	39	153	(0)	153	59
60	Wiring & Pipes	2001	8,766	225	39	225	(0)	225	60
61	Electrical	2001	158	4	39	4	(0)	4	61
62	Sprinkler System	2001	1,424	37	39	37	0	37	62
63	Roofing	2001	566	15	39	15	0	15	63
64	Carpet	2001	1,683	412	39	43	(369)	211	64
65	Carpet	2001	434	106	39	11	(95)	54	65
66	Handrail	2001	23,600	5,780	39	605	(5,175)	2,965	66
67	Nursing Station	2001	6,000	1,469	39	154	(1,315)	754	67
68	Handrail	2001	16,800	4,114	39	431	(3,683)	1,571	68
69	Front Hallway	2001	2,400	588	39	62	(526)	602	69
70	TOTAL (lines 4 thru 69)		$ 6,901,796	$ 32,083		$ 248,917	$ 216,834	$ 1,610,160	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,901,796	$ 32,083		$ 248,917	$ 216,834	$ 1,610,160	1
2	Front Reception	2001	4,800	1,176	39	123	(1,053)	603	2
3	Elevator	2001	3,900	955	39	100	(855)	490	3
4	Handrail	2001	11,800	2,890	39	303	(2,587)	1,483	4
5	Employee Kitchen	2001	1,900	465	39	49	(416)	239	5
6	Nursing Station	2001	10,000	2,449	39	256	(2,193)	556	6
7	Elevator Improvements	2002	2,422	58	39	57	(1)	57	7
8	Roofing	2002	2,838	62	39	61	(1)	61	8
9	Floor Remodeling	2002	4,756	114	39	112	(2)	112	9
10	Floor Remodeling	2002	3,807	83	39	82	(1)	82	10
11	Floor Remodeling	2002	11,296	278	39	266	(12)	266	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,959,315	$ 40,613		$ 250,326	$ 209,713	$ 1,614,109	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 845,875	$ 102,304	$ 84,588	$ (17,717)	10	$ 586,274	71
72	Current Year Purchases	138,831	30,105	6,942	(23,163)	10	6,942	72
73	Fully Depreciated Assets	249,000		0	0	5	249,000	73
74					0			74
75	TOTALS	$ 1,233,706	$ 132,409	$ 91,529	$ (40,880)		$ 842,216	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,243,021	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,022	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 341,855	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 168,834	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,456,325	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,713 Description: Ice Maker - $1,740; Copier - $2,551; DishWaher - $210; Water purifier - $1,212
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2002 Volvo	$ 742.00	$ 4,449	17
18	Administrative	2000 Dodge Caravan	369.00	4,428	18
19					19
20					20
21	TOTAL		$ 1,111.00	$ 8,877	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Emerald Park Health Care Center | STATE OF ILLINOIS # 0040816 | Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 6,464	$		$ 6,464	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			329			329	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			4,542			4,542	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				40,370		40,370	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Rentals	39-3					11,193		11,193	13
14	TOTAL			$		$ 11,335	$ 51,563		$ 62,898	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (210,997)	$ (109,047)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,869,602	2,869,602	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,499	45,499	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	406,794	1,152,748	8
9	Other(specify): Escrow Account		82,397	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,110,898	$ 4,041,199	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	360,000	360,000	11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		6,402,500	14
15	Leasehold Improvements, at Historical Cost	837,449	837,449	15
16	Equipment, at Historical Cost	1,063,139	1,312,139	16
17	Accumulated Depreciation (book methods)	(889,509)	(2,281,042)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	244,323	244,323	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,615,402	$ 6,925,369	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,726,300	$ 10,966,568	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,978	$ 128,978	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	251,364	251,364	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	291,600	291,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	1,591,439	1,591,439	36
37	Accrued Expenses	918,945	918,945	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,182,326	$ 3,182,326	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,440	7,243,225	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,440	$ 7,243,225	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,201,766	$ 10,425,551	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,524,534	$ 541,017	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,726,300	$ 10,966,568	48

*(See instructions.)

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,997,854	1
2	Restatements (describe):		2
3	Prior year adjustment	(1,428)	3
4	Medicade Adjustment	4,706	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,001,132	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(86,598)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(390,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (476,598)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,524,534	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,864,098	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,864,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	23,355	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 23,355	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	930	18
19	Laboratory	6,638	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,568	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,226	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,226	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Gain on Sale of Equip.	7,814	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,814	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,905,061	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,436,756	31
32	Health Care	2,710,287	32
33	General Administration	1,449,416	33
	B. Capital Expense		
34	Ownership	1,201,195	34
	C. Ancillary Expense		
35	Special Cost Centers	62,898	35
36	Provider Participation Fee	136,328	36
	D. Other Expenses (specify):		
37	Franchise Tax	78	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,996,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	(91,897)	41
42	**Income Taxes**	5,299	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (86,598)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,240	4,240	$ 87,981	$ 20.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,600	14,442	329,321	22.80	3
4	Licensed Practical Nurses	48,980	51,937	997,834	19.21	4
5	Nurse Aides & Orderlies	104,663	109,899	897,291	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,956	8,612	91,075	10.58	8
9	Activity Director	2,160	2,160	25,012	11.58	9
10	Activity Assistants	1,111	1,497	49,904	33.34	10
11	Social Service Workers	7,169	7,317	109,456	14.96	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,160	23,726	10.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,597	30,267	200,948	6.64	15
16	Dishwashers					16
17	Maintenance Workers	2,088	2,231	58,843	26.38	17
18	Housekeepers	38,560	40,407	303,858	7.52	18
19	Laundry	9,603	10,377	80,370	7.75	19
20	Administrator	3,160	3,160	104,000	32.91	20
21	Assistant Administrator	298	298	34,389	115.40	21
22	Other Administrative	550	550	31,538	57.34	22
23	Office Manager	261	261	14,684	56.26	23
24	Clerical	10,395	10,733	165,576	15.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Security	6,795	7,103	47,536	6.69	33
34	TOTAL (lines 1 - 33)	292,346	307,651	$ 3,653,342 *	$ 11.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,780	1-3	35
36	Medical Director	O	7,000	9-3	36
37	Medical Records Consultant	N	3,968	10-3	37
38	Nurse Consultant	T	2,153	10-3	38
39	Pharmacist Consultant	H	1,860	10-3	39
40	Physical Therapy Consultant	L	6,885	10A-3	40
41	Occupational Therapy Consultant	Y	5,364	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	10,163	10A-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 47,173		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Mildred Prero	Administrator	0.00%	104,000
Henry Mermelstein	Administrative	0.00%	26,832
Marvin Mermelstein	Asst Administrator	24.50%	34,389
Morris Esformes	Administrative	51.00%	4,706
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,927

B. Administrative - Other

Description	Amount
Management Fees	$ 23,357
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,357
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver & Co	Accounting	$ 11,550
Health Data Systems, Inc.	Computer Services	4,823
Medi.Com	Computer Services	1,240
LTC Solutions	Computer Services	1,320
Brenda Cohen	Collections	6,880
Richard Peelo	Healthcare Consulting	3,800
N.H.P.S. Personnel	Employment Agency	24,020
Personnel Planner	U/C Consulting	3,210
See Attached	Legal Fees	13,738
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,581

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,735
Unemployment Compensation Insurance	57,622
FICA Taxes	272,231
Employee Health Insurance	59,106
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	94,690
Employee Dental	7,065
Other Employee Benefits	
Allocation from Management Company	17,276
TOTAL (agree to Schedule V, line 22, col.8)	$ 613,725

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,629
Health Care Worker Background Check	1,896
(Indicate # of checks performed 271)	
IL Council on Long Term Care	4,806
Div of Mng Services	195
Non Deductible Dues	(1,444)
Sec of State	278
Village of Evergreen Pakk	8,248
Cook County Collector	123
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,931

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,138
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,138

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $4,806**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **136,328**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0.00%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees